(7) PAYMENTS TO NETWORKS AND PROVIDERS. (a) *Payments to health care networks.* 1. On behalf of each participant who selects or has been assigned to a certified health care network that has been classified under sub. (5) (c) as the lowest-cost network or a low-cost network and as performing well on quality measures, the board shall pay monthly to the health care network the full risk-adjusted per-member per-month amount that was bid by the network. The dollar amount shall be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who selects or is assigned to the lowest-cost network or a low-cost network shall not be required to pay any additional amount to the network.

2. If a participant chooses instead to enroll in a certified health care network that has been classified under sub. (5) (c) as a higher-cost network, the board shall pay monthly to the chosen health care network an amount equal to the bid submitted by the network that the board classified under sub. (5) (c) as the lowest-cost network and as having performed well on quality measures. The dollar amount shall be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who chooses to enroll in a higher-cost network shall be required to pay monthly, in addition to the amount paid by the board, an amount sufficient to ensure that the chosen network receives the full price bid by that network.

3. The board may retain a percentage of the dollar amounts established for each participant under subds. 1. and 2. to pay to certified health care networks that have incurred disproportionate risk not fully compensated for by the actuarial adjustment in the amount established for each eligible person. Any payment to a certified health

care network under this subdivision shall reflect the disproportionate risk incurred by the health care network.

(b) *Payments to fee-for-service providers.* 1. The board shall establish provider payment rates that will be paid to providers of covered services and articles that are provided to participants who choose the fee-for-service option under sub. (2) (a). The payment rates shall be fair and adequate to ensure that this state is able to retain the highest quality of medical practitioners. The board shall limit increases in the provider payment rate for each service or article such that any increase in per person spending under the plan does not exceed the national rate of medical inflation.

2. Except for deductibles, copayments, coinsurance, and any other cost sharing required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under subd. 1. and may not bill a participant who receives the service or article for any amount by which the charge for the service or article is reduced under subd. 1.

3. The board, with the assistance of its actuarial consultants, shall establish the monthly risk-adjusted cost of the fee-for-service option offered to participants under sub. (2) (a). The board shall classify the fee-for-service option in the same manner as the board classifies certified health care networks under sub. (5) (c).

4. If the board has determined under sub. (5) (c) that there is at least one certified low-cost health care network in an area, which may be the lowest-cost health care network, and if the fee-for-service option offered in that area has been classified as a higher-cost choice under subd. 3., the cost to a participant enrolling in the fee-for-service option shall be determined as follows:

a. If there are available to the participant 3 or more certified health care networks classified under sub. (5) (c) as low-cost networks, or as the lowest-cost network and 2 or more low-cost networks, the participant shall pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established under subd. 3. for the fee-for-service option, except that the amount paid may not exceed $100 per month for an individual, or $200 per month for a family, as adjusted for medical inflation.

b. If there are available to the participant 2 certified health care networks classified under sub. (5) (c) as low-cost networks, or as the lowest-cost network and one low-cost network, the participant shall pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established under subd. 3. for the fee-for-service option, except that the amount paid may not exceed $65 per month for an individual, or $125 per month for a family, as adjusted for medical inflation.

c. If there is available to the participant only one certified health care network classified under sub. (5) (c) as a low-cost network, or as the lowest-cost network, the person shall pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established under subd. 3. for the fee-for-service option, except that the amount paid may not exceed $25 per month for an individual, and $50 per month for a family, as adjusted for medical inflation.

5. If the board has determined, under sub. (5) (c), that there is no certified lowest-cost health care network or low-cost health care network in the area, there shall be no extra cost to the participant enrolling in the fee-for-service option.

(8) INCENTIVE PAYMENTS TO FEE-FOR-SERVICE PROVIDERS. Health care providers and facilities providing services under the fee-for-service option under sub. (2) (a)

shall be encouraged to collaborate with each other through financial incentives established by the board. Providers shall work with facilities to pool infrastructure and resources; to implement the use of best practices and quality measures; and to establish organized processes that will result in high-quality, low-cost medical care. The board shall establish an incentive payment system to providers and facilities that comply with this subsection, in accordance with criteria established by the board.

(9) PHARMACY BENEFIT. Except for prescription drugs to which a deductible applies, the board shall assume the risk for, and pay directly for, prescription drugs provided to participants. In implementing this requirement, the board shall replicate the prescription drug buying system developed by the group insurance board for prescription drug coverage under the state employee health plan under s. 40.51 (6), unless the board determines that another approach would be more cost-effective. The board may join the prescription drug purchasing arrangement under this chapter with similar arrangements or programs in other states to form a multistate purchasing group to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices, or to contract with a 3rd party, such as a private pharmacy benefits manager, to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices.

260.35 Subrogation. The board and authority are entitled to the right of subrogation for reimbursement to the extent that a participant may recover reimbursement for health care services and items in an action or claim against any 3rd party.

260.37 Employer-provided health care benefits. Nothing in this chapter prevents an employer, or a Taft-Hartley trust on behalf of an employer, from paying

all or part of any cost sharing under s. 260.20 or 260.30, or from providing any health care benefits not provided under the plan, for any of the employer's employees.

260.40 Assessments, individuals and businesses. (1) DEFINITIONS. In this section:

(a) "Department" means the department of revenue.

(b) "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full-time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(c) "Eligible individual" means an individual who is eligible to participate in the plan, other than an employee or a self-employed individual.

(d) "Employee" means an individual who has an employer.

(e) "Employer" means a person who is required under the Internal Revenue Code to file form 941.

(em) "Household" means an individual who is either an eligible individual, an employee, or a self-employed individual, and the individual's dependents.

(f) "Medical inflation" means the percentage change between the U.S. consumer price index for all urban consumers, U.S. city average, for the medical care group only, including medical care commodities and medical care services, for the month of August of the previous year and the U.S. consumer price index for all urban consumers, U.S. city average, for the medical care group only, including medical care commodities and medical care services, for the month of August 2007, as determined by the U.S. department of labor.

(g) "Poverty line" means the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family.

(h) "Self-employed individual" means an individual who is required under the Internal Revenue Code to file schedule SE.

(i) "Small employer" means an employer who has no more than 20 employees.

(j) "Social security wages" means:

1. For purposes of sub. (2) (a), the amount of wages, as defined in section 3121 (a) of the Internal Revenue Code, paid to an employee by an employer in a taxable year, up to a maximum amount that is equal to the social security wage base.

2. For purposes of sub. (2) (b), the amount of net earnings from self-employment, as defined in section 1402 (a) of the Internal Revenue Code, received by an individual in a taxable year, up to a maximum amount that is equal to the social security wage base.

3. For purposes of sub. (3), the amount of wages, as defined in section 3121 (a) of the Internal Revenue Code, paid by an employer in a taxable year with respect to employment, as defined in section 3121 (b) of the Internal Revenue Code, up to a maximum amount that is equal to the social security wage base multiplied by the number of the employer's employees.

(2) INDIVIDUALS. Subject to sub. (4), the board shall calculate the following assessments, based on its anticipated revenue needs:

(a) For an employee who is under the age of 65, a percent of social security wages that is at least 2 percent and not more than 4 percent, subject to the following:

1. If the employee has social security wages that are 150 percent or less of the poverty line, the employee may not be assessed.

2. If the employee has no dependents and his or her social security wages are more than 150 percent and 200 percent or less of the poverty line the assessment shall be in an amount, as determined by the board on a sliding scale based on the

employee's social security wages, that is between zero percent and 4 percent of the employee's social security wages.

3. If the employee has one or more dependents, or is a single individual who is pregnant, and the employee's social security wages are more than 150 percent and 300 percent or less of the poverty line the assessment shall be in an amount, as determined by the board on a sliding scale based on the employee's social security wages, that is between zero percent and 4 percent of the employee's social security wages.

(b) For a self-employed individual who is under the age of 65, a percent of social security wages that is at least 9 percent and not more than 10 percent.

(c) For an eligible individual who has no social security wages under sub. (1) (j) 1. or 2. or, from an employer, under sub. (1) (j) 3., 10 percent of federal adjusted gross income, up to the maximum amount of income that is subject to social security tax.

(3) EMPLOYERS. (a) Subject to ~~pars.~~ par. (b) and (c) and sub. (4), the board shall calculate an assessment, based on its anticipated revenue needs, that is a percent of aggregate social security wages that is at least 9 percent and not more than 12 percent.

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(b) For taxable year beginning after December 31, 2009, and before January 1, 2011, the assessment imposed on a small employer shall be 33 percent of the amount calculated for that employer under par. (a).

(c) For taxable year beginning after December 31, 2010, and before January 1, 2012, the assessment imposed on a small employer shall be 67 percent of the amount calculated for that employer under par. (a).

(4) COLLECTION AND CALCULATION OF ASSESSMENTS. (a) For taxable years beginning after December 31, ~~2008~~ 2009, the department shall impose on, and collect from, individuals the assessment amounts that the board calculates under sub. (2), either through an assessment that is collected as part of the income tax under subch. I of ch. 71, or through another method devised by the department. For taxable years beginning after December 31, ~~2008~~ 2009, the department shall impose on, and collect from, employers the assessment amounts that the board calculates under sub. (3), either through an assessment that is collected as part of the tax under subch. IV of ch. 71, or through another method devised by the department. Section 71.80 (1) (c), as it applies to ch. 71, applies to the department's imposition and collection of assessments under this section.

(b) The amounts that the department collects under par. (a) shall be deposited into the Healthy Wisconsin trust fund under s. 25.775.

(c) The board may annually increase or decrease the amounts that may be assessed under subs. (2) and (3). No annual increase under this paragraph may exceed the percentage increase for medical inflation unless a greater increase is provided for by law.

(d) The maximum amount of assessment that the department may impose on, and collect from, a household under par. (a) is 4 percent of the annual limit on the contribution and benefit base of the Old-Age, Survivors, and Disability Insurance program, as calculated annually by the U.S. social security administration.

260.49 Advisory committee. (1) DUTIES. The board shall establish a health care advisory committee to advise the board on all of the following:

(a) Matters related to promoting healthier lifestyles.

(b) Promoting health care quality.

(c) Increasing the transparency of health care cost and quality information.

(d) Preventive care.

(e) Early identification of health disorders.

(f) Disease management.

(g) The appropriate use of primary care, medical specialists, prescription drugs, and hospital emergency rooms.

(h) Confidentiality of medical information.

(i) The appropriate use of technology.

(j) Benefit design.

(k) The availability of physicians, hospitals, and other providers.

(L) Reducing health care costs.

(m) Any other subject assigned to it by the board.

(n) Any other subject determined appropriate by the committee.

(2) MEMBERSHIP. The board shall appoint as members of the committee all of the following individuals:

(a) At least one member designated by the Wisconsin Medical Society, Inc.

(b) At least one member designated by the Wisconsin Academy of Family Physicians.

(c) At least one member designated by the Wisconsin Hospital Association, Inc.

(d) One member designated by the president of the Board of Regents of the University of Wisconsin System who is knowledgeable in the field of medicine and public health.

(e) One member designated by the president of the Medical College of Wisconsin.

(f) Two members designated by the Wisconsin Nurses Association, the Wisconsin Federation of Nurses and Health Professionals, and the Service Employees International Union.

(g) One member designated by the Wisconsin Dental Association.

(h) One member designated by statewide organizations interested in mental health issues.

(i) One member representing health care administrators.

(j) Other members representing health care professionals.

SECTION 77. 285.59 (1) (b) of the statutes is amended to read:

285.59 **(1)** (b) "State agency" means any office, department, agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law ~~which~~ that is entitled to expend moneys appropriated by law, including the legislature and the courts, the Wisconsin Housing and Economic Development Authority, the Bradley Center Sports and Entertainment Corporation, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, ~~and~~ the Wisconsin Health and Educational Facilities Authority, and the Healthy Wisconsin Authority.

SECTION 78. 609.01 (7) of the statutes is repealed.

SECTION 79. 609.10 of the statutes is repealed.

SECTION 80. 609.20 (1m) (c) of the statutes is repealed.

SECTION 81. 609.20 (1m) (d) of the statutes is repealed.

SECTION 82. 628.36 (4) (a) (intro.) of the statutes is amended to read:

628.36 **(4)** (a) (intro.) The commissioner shall provide information and assistance to ~~the department of employee trust funds,~~ employers and their

employees, providers of health care services, and members of the public, as provided in par. (b), for the following purposes:

SECTION 83. 628.36 (4) (b) 1. of the statutes is repealed.

SECTION 84. 628.36 (4) (b) 2. of the statutes is repealed.

SECTION 85. 628.36 (4) (b) 3. of the statutes is repealed.

SECTION 86. 632.87 (5) of the statutes is amended to read:

632.87 **(5)** No insurer ~~or self-insured school district, city or village~~ may, under a policy, plan, or contract covering gynecological services or procedures, exclude or refuse to provide coverage for Papanicolaou tests, pelvic examinations, or associated laboratory fees when the test or examination is performed by a licensed nurse practitioner, as defined in s. 632.895 (8) (a) 3., within the scope of the nurse practitioner's professional license, if the policy, plan, or contract includes coverage for Papanicolaou tests, pelvic examinations, or associated laboratory fees when the test or examination is performed by a physician.

SECTION 87. 632.895 (8) (f) 4. of the statutes is created to read:

632.895 **(8)** (f) 4. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 88. 632.895 (9) (d) 4. of the statutes is created to read:

632.895 **(9)** (d) 4. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 89. 632.895 (10) (a) of the statutes is amended to read:

632.895 **(10)** (a) Except as provided in par. (b), every disability insurance policy ~~and every health care benefits plan provided on a self-insured basis by a county board under s. 59.52 (11), by a city or village under s. 66.0137 (4), by a political subdivision under s. 66.0137 (4m), by a town under s. 60.23 (25), or by a school district~~

~~under s. 120.13 (2)~~ shall provide coverage for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and family services under s. 254.158.

SECTION 90. 632.895 (10) (b) 6. of the statutes is created to read:

632.895 **(10)** (b) 6. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 91. 632.895 (11) (a) (intro.) of the statutes is amended to read:

632.895 **(11)** (a) (intro.) Except as provided in par. (e), every disability insurance policy~~, and every self-insured health plan of the state or a county, city, village, town or school district,~~ that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue shall provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

SECTION 92. 632.895 (11) (c) 1. of the statutes is amended to read:

632.895 **(11)** (c) 1. The coverage required under this subsection may be subject to any limitations, exclusions, or cost-sharing provisions that apply generally under the disability insurance policy ~~or self-insured health plan~~.

SECTION 93. 632.895 (11) (d) of the statutes is amended to read:

632.895 **(11)** (d) Notwithstanding par. (c) 1., an insurer ~~or a self-insured health plan of the state or a county, city, village, town or school district~~ may require that an insured obtain prior authorization for any medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders.

SECTION 94. 632.895 (11) (e) 3. of the statutes is created to read:

632.895 **(11)** (e) 3. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 95. 632.895 (12) (b) (intro.) of the statutes is amended to read:

632.895 **(12)** (b) (intro.) Except as provided in par. (d), every disability insurance policy~~, and every self-insured health plan of the state or a county, city, village, town or school district,~~ shall cover hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, if any of the following applies:

SECTION 96. 632.895 (12) (c) of the statutes is amended to read:

632.895 **(12)** (c) The coverage required under this subsection may be subject to any limitations, exclusions, or cost-sharing provisions that apply generally under the disability insurance policy ~~or self-insured plan~~.

SECTION 97. 632.895 (13) (a) of the statutes is amended to read:

632.895 **(13)** (a) Every disability insurance policy~~, and every self-insured health plan of the state or a county, city, village, town or school district,~~ that provides coverage of the surgical procedure known as a mastectomy shall provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

SECTION 98. 632.895 (13) (b) of the statutes is amended to read:

632.895 **(13)** (b) The coverage required under par. (a) may be subject to any limitations, exclusions, or cost-sharing provisions that apply generally under the disability insurance policy ~~or self-insured health plan~~.

SECTION 99. 632.895 (14) (b) of the statutes is amended to read:

632.895 **(14)** (b) Except as provided in par. (d), every disability insurance policy~~, and every self-insured health plan of the state or a county, city, town, village or school~~

~~district,~~ that provides coverage for a dependent of the insured shall provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured.

SECTION 100. 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy ~~or plan~~. This paragraph applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

SECTION 101. 632.895 (14) (d) 7. of the statutes is created to read:

632.895 **(14)** (d) 7. A disability insurance policy providing only health care benefits not provided under the Healthy Wisconsin Plan under ch. 260.

SECTION 102. Nonstatutory provisions.

(1) HEALTHY WISCONSIN PLAN.

(a) *Legislative findings.* In establishing the Healthy Wisconsin Plan under chapter 260 of the statutes, as created by this act, the legislature finds all of the following:

1. 'Costs.' Health care costs in Wisconsin are rising at an unsustainable rate making the need for comprehensive reform urgent. Rising costs are seriously threatening the ability of Wisconsin businesses to globally compete; farms to thrive; government to provide needed services; schools to educate; and local citizens to form new and successful business ventures. Some indicators of rising costs are the following:

a. Total health care spending in Wisconsin in 2007 is projected to be $42.3 billion, and is projected to grow 82 percent, to $76.9 billion, in the next decade.

b. The cost of employer-provided health care in Wisconsin increased by 9.3 percent in 2006, averaging $9,516 per employee. This figure is 26 percent more than the national average.

c. Employee premium contributions and out-of-pocket costs are rising faster than wages.

d. Rising costs have led to a decline in employer-provided health benefits. In 1979, 73 percent of private-sector Wisconsin workers had employer-based health insurance coverage; however, only 57 percent received health benefits in 2004.

e. At least one-half of all personal bankruptcies in the United States are the result of medical expenses. Over 75.7 percent of this group had insurance at the onset of illness. In 2004, there were 13,454 medical bankruptcies in Wisconsin affecting 37,360 people.

f. The costs of health services provided to individuals who are unable to pay are shifted to others. Of the $22 billion charged by hospitals in 2005, $736,000,000 was not collected. Those who bear the burden of this cost shift have an increasingly difficult time paying their own health care costs.

2. 'Access.' There is a large and increasing number of people who have no health insurance or who are underinsured. For this growing population, health care is unaffordable and, most often, not received in the most timely and effective manner. Some indicators of lack of access to health care are as follows:

a. Over one 500,000 Wisconsin residents were uninsured at any given point during 2007.

b. Over 65 percent of the uninsured in Wisconsin are employed.

c. The uninsured are less likely to seek care and, thus, have poorer health outcomes compared to the insured population.

d. In 2007, total spending on the uninsured in Wisconsin is projected to reach over $1,000,000,000. About 23.2 percent of this amount will be in the form of uncompensated care; 21.7 percent will be provided through public programs; and 37.5 percent will be paid by the uninsured individuals.

3. 'Inequity.' The health care system contains inequities. Some indicators of inequity are as follows:

a. Wisconsin businesses are competing on an uneven playing field. The majority of Wisconsin businesses that do insure their workers are subsidizing those businesses that are not paying their fair share for health care.

b. Our current system forces the sick and the aging to pay far higher premiums than the healthy and those covered under group plans, rather than spreading the risk across the broadest pool possible.

c. The uninsured face medical charges by hospitals, doctors, and other health care providers that are 2.5 times what public and private health insurers pay.

4. 'Inefficiency.' Wisconsin does not have a clearly defined, integrated health care system. Our health care system is complex, fragmented, and disease-focused rather than health-focused, resulting in massive inefficiencies and placing inordinate administrative burdens on health care professionals. Some indicators of inefficiency are as follows:

a. Health care financing is accomplished through a patchwork of public programs, private sector employer-sponsored self-insurance, commercial insurance, and individual payers. The most recent study for Wisconsin estimates that about 27 cents of every health care dollar is spent on marketing, overhead, and administration, leaving only 73 cents left to deliver medical care.

b. This fragmentation and misaligned financial incentives lead, in some instances, to excessive or inadequate care and create barriers to coordination and accountability among health care professionals, payers, and patients.

c. The Institute of Medicine estimates that between 30 cents and 40 cents of every health care dollar is spent on costs of poor quality — overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication, and inefficiency. Included in this inefficiency are an unacceptable number of adverse events attributable to medical errors. Patients receive appropriate care based on known "best practices" only about one-half of the time.

d. The best care results from the conscientious, explicit, and judicious use of current best evidence and knowledge of patient values by well-trained, experienced clinicians.

5. 'Limitations on reform.' Federal laws and programs, such as Medicaid, Medicare, Tri-Care, and Champus, constrain Wisconsin's ability to establish immediately a fully integrated health care system.

6. 'Wisconsin as a laboratory for the nation.' Wisconsin is in a unique position to successfully implement major health care reform. Many providers are already organized into comprehensive delivery systems and have launched innovative pilot programs to improve both the quality and efficiency of their care. Wisconsin is at the forefront in developing systems for health information transparency. Organizations such as the Wisconsin Collaborative for Healthcare Quality, Wisconsin Health Information Organization, and the Wisconsin Hospital Association have launched ambitious projects to provide data on quality, safety, and pricing.

(b) *Initial terms of Healthy Wisconsin Authority board.* Notwithstanding the lengths of terms of the members of the board of the Healthy Wisconsin Authority

specified in section 260.05 (1) of the statutes, as created by this act, the initial members shall be appointed for the following terms:

1. One member each from section 260.05 (1) (a), (b), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2010.

2. One member each from section 260.05 (1) (a), (b), and (e) of the statutes, as created by this act, for terms that expire on July 1, 2011.

3. One member each from section 260.05 (1) (c), (e), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2012.

4. One member each from section 260.05 (1) (d), (f), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2013.

5. One member each from section 260.05 (1) (a) and (b) of the statutes, as created by this act, for terms that expire on July 1, 2014.

6. One member each from section 260.05 (1) (a) and (b) of the statutes, as created by this act, for terms that expire on July 1, 2015.

(c) *Provisional appointments.* Notwithstanding the requirement for senate confirmation of the appointment of the members of the board of the Healthy Wisconsin Authority under section 260.05 (1) of the statutes, as created by this act, the initial members may be provisionally appointed by the governor, subject to confirmation by the senate. Any such appointment shall be in full force until acted upon by the senate, and when confirmed by the senate shall continue for the remainder of the term, or until a successor is chosen and qualifies. A provisional appointee may exercise all of the powers and duties of the office to which such person is appointed during the time in which the appointee qualifies. Any appointment made under this subsection that is withdrawn or rejected by the senate shall lapse. When a provisional appointment lapses, a vacancy occurs. Whenever a new

legislature is organized, any appointments then pending before the senate shall be referred by the president to the appropriate standing committee of the newly organized senate.

(d) *Property tax credit.* If with respect to levies imposed for 2010, any taxing jurisdiction, as defined in section 74.01 (7) of the statutes, reduces the costs of providing health care coverage to its employees as a result of providing that coverage under the Healthy Wisconsin Plan under chapter 260 of the statutes, as created by this act, together with any supplemental coverage needed to ensure that the health care coverage provided to employees of the taxing jurisdiction is actuarially equivalent to the coverage they received in 2009, the taxing jurisdiction shall distribute at least 50 percent of the savings to the property taxpayers in the taxing jurisdiction as a reduction in the property tax assessments as of January 1, 2010. The reduction shall be calculated based on the equalized value of the property, as determined under section 70.57 of the statutes, and shall reduce the property taxes otherwise payable in that year.

SECTION 103. Effective dates. This act takes effect on the day after publication, except as follows:

(1) HEALTHY WISCONSIN PLAN. The treatment of sections 13.94 (1) (dj) and (1s) (c) 5., 16.004 (7d) and (7h), 40.05 (4) (a) 4., (ag) (intro.), (ar), (b), and (be) and (4g) (d), 40.51 (1), (2), (7), (8), and (8m), 40.52 (1) (intro.), (1m), and (2), 40.98 (2) (a) 1., 49.45 (54), 49.473 (2) (c), 49.665 (5) (ag), 49.68 (3) (d) 1., 49.683 (3), 49.685 (6) (b), 49.687 (1m) (d), 59.52 (11) (c), 60.23 (25), 66.0137 (4), (4m) (b), and (5), 109.075 (9), 111.70 (1) (dm) and (4) (cm) 8s., 111.91 (2) (pt), 120.13 (2) (b) and (g), 149.12 (2) (em), 609.01 (7), 609.10, 609.20 (1m) (c) and (d), 628.36 (4) (a) (intro.) and (b) 1., 2., and 3., 632.87 (5), and 632.895 (8) (f) 4., (9) (d) 4., (10) (a) and (b) 6., (11) (a) (intro.), (c) 1., (d), and

(e) 3., (12) (b) (intro.) and (c), (13) (a) and (b), and (14) (b), (c), and (d) 7. of the statutes, the renumbering and amendment of sections 40.51 (6) and 62.61 of the statutes, and the creation of sections 40.51 (6) (b) and 62.61 (1) (b) of the statutes take effect on January 1, 2010.

(END)

2007-2008 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

INSERT 19-3

Estimated disbursements under this paragraph shall not be included in the schedule under s. 20.005.

(END OF INSERT 19-3)

Insert 61 - 19 JK

If a small employer begins doing business in this state, as defined in s. 71.22 (1r), during the period beginning on January 1, 2010, and ending on December 31, 2012, for the small employer's first taxable year the assessment imposed on the small employer shall be 33 percent of the amount calculated for that employer under par. (a) and for the small employer's 2nd taxable year the assessment imposed on the small employer shall be 67 percent of the amount calculated for that employer under par. (a).